Personal ID label:
Name: _____
DOB: _____
IHI number: _____
CPMS/DMS No: _____
Location: _____

Dublin North City Adult Mental Health Services

Antipsychotic Initiation / Review Checklist

DATE: _____

Medicines Reconciliation (*to be completed annually*)

Source	Name	Contact Number	Healthmail
Community Pharmacy: ☐			
GP: ☐			
CMHT: ☐			
Other: ☐			

Medication List	Dose	Frequency	Comments
Mental Health Medication			
All other Medications			

Review Medication for Drug Interaction: YES ☐ **NO** ☐ **OTC Medication: YES** ☐ **NO** ☐

Comment: _____

_____

Pregnancy/Breastfeeding/Menstrual Cycle	**Pregnancy** ☐	**Breastfeeding** ☐	**Changes in Menstrual Cycle** ☐

Co-Morbidities (*e.g. Renal Impairment,Metabolic Syndrome)*

_____

_____

Side Effects

YES ☐ NO ☐ Comment: _____

Agitation ☐	Breast tenderness ☐	Constipation ☐	Drowsiness ☐	Emotional blunting ☐	Muscle spasms ☐
Blurred Vision ☐	Changes to libido ☐	Dizziness ☐	Dry mouth ☐	Muscle stiffness ☐	Weight gain ☐

Acute Illness

YES ☐ NO ☐ Comment: _____

Complete for ALL PATIENTS taking Clozapine (*to be completed every three months*)

Clozaril ☐ CPMS Number: _____

Denzapine ☐ DMS Number: _____

Has the persons smoking status changed Yes ☐ No ☐

Date of last Clozapine level _____ Total daily dose (TDD) _____

Clozapine level _____ Norclozapine level _____

Bowel movement frequency _____ Laxative use Yes ☐ No ☐

Name Print: _____